State: *Arkansas* ***Filing Company:*** *Kansas City Life Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *A167 - Application*
Project Name/Number: *A167 - Application/A167*

Filing at a Glance

Company:	Kansas City Life Insurance Company
Product Name:	A167 - Application
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	08/15/2012
SERFF Tr Num:	KCLF-128617026
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	A167
Implementation Date Requested:	On Approval
Author(s):	Bobby Stow
Reviewer(s):	Linda Bird (primary)
Disposition Date:	08/21/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Kansas City Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: A167 - Application
Project Name/Number: A167 - Application/A167

General Information

Project Name: A167 - Application
Project Number: A167
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Bobby Stow

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/21/2012
State Status Changed: 08/21/2012
Created By: Bobby Stow
Corresponding Filing Tracking Number:

Filing Description:

With this filing, Kansas City Life Insurance Company is submitting for review and approval A167-AR, Application for Life Insurance. The Medical Information Bureau, MIB, has mandated a change to the Authorization for the Release of Medical Information. The required change has been made to previously approved A160-AR to comply with the MIB mandated change. A160-AR was approved by the Arkansas Department of Insurance on February 18, 2010.

The Authorization for the Release of Medical Information contained on page 10 has been amended to include the required change to the authorization. The following sentence has been added to the first paragraph on page 10 of A167-AR: "I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB." No part of the application has been altered or changed, and remains identical to the previously approved A160-AR.

Company and Contact

Filing Contact Information

Bobby Stow, Compliance Analyst I
3520 Broadway St.
Kansas City, MO 64111

bstow@kclife.com
816-753-7299 [Phone] 8852 [Ext]
816-753-3018 [FAX]

Filing Company Information

Kansas City Life Insurance Company
P O Box 219139
Kansas City, MO 64121-9139
(800) 821-5529 ext. [Phone]

CoCode: 65129
Group Code: 588
Group Name:
FEIN Number: 44-0308260

State of Domicile: Missouri
Company Type: Life
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? Yes
Fee Explanation: Missouri retaliatory fee.
Per Company: No

Company	Amount	Date Processed	Transaction #
Kansas City Life Insurance Company	$50.00	08/15/2012	61711471

SERFF Tracking #:	*KCLF-128617026*	***State Tracking #:***		***Company Tracking #:***	*A167*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*A167 - Application*		
Project Name/Number:	*A167 - Application/A167*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	08/21/2012	08/21/2012

SERFF Tracking #:	*KCLF-128617026*	***State Tracking #:***		***Company Tracking #:***	*A167*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*A167 - Application*		
Project Name/Number:	*A167 - Application/A167*		

Disposition

Disposition Date: 08/21/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking #:	*KCLF-128617026*	***State Tracking #:***		***Company Tracking #:***	*A167*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*A167 - Application*		
Project Name/Number:	*A167 - Application/A167*		

Form Schedule

Lead Form Number: A167

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		A167-AR	AEF	Application for Life Insurance	Initial:		A167-AR.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

KANSAS CITY LIFE INSURANCE COMPANY

Application for Life Insurance

PERSONAL DATA

Proposed Insured Information

Full Name _____ (First / Middle / Last) ☐ Male ☐ Female Date of Birth ____/____/____ (Month / Day / Year)

State of Birth _____ SSN _____ ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated

Former Full Name _____ (First / Middle / Last)

Street Address _____ City _____ State _____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cellular Phone (____) _____

E-Mail Address _____ Driver's License No. _____ State of Issue _____

Employer _____ Street Address _____

City _____ State _____ Zip _____

Occupation and Duties _____ Years Employed _____

If you have been employed at your current position less than **two** years, complete the following:

Former Employer _____ Occupation and Duties _____

Ownership Information

(The Insured will be the Owner unless otherwise stated.)

Primary Owner _____ (First / Middle / Last) ☐ Male ☐ Female Date of Birth ____/____/____ (Month / Day / Year)

State of Birth _____ SSN or Tax ID _____ Relationship to Insured _____

Street Address _____ City _____ State _____ Zip _____

Successor Owner _____ Relationship to Insured _____

(If there are multiple Successor Owners, show order and distribution in Special Requests.)

Applicant Information

(Complete the following information if the applicant is someone other than the Insured or the Owner.)

Applicant _____ (First / Middle / Last) ☐ Male ☐ Female Relationship to Insured _____

Street Address _____ City _____ State _____ Zip _____

Beneficiary Information* (with right to change)

Primary Beneficiary (First and Last Name) — Relationship to Insured

_____ _____

_____ _____

Contingent Beneficiary (First and Last Name) — Relationship to Insured

_____ _____

_____ _____

*Unless otherwise stated, benefits are payable equally to the named beneficiaries or to the surviving beneficiaries.

Special Requests (Policy date, alternate or additional policy, existing PAC or CB number, etc.) **Home Office Endorsements**

PLAN DATA

Life Insurance

Plan Name _____ Specified/Face Amount $ _____ UL Coverage Option ☐ A ☐B ☐ C (if available)

Planned/Annual Premium $ _____ DEFRA Compliance ☐ Guideline Premium Test (GLP) ☐ Cash Value Accumulation Test (CVAT)

Special Class Premium $ _____ Reason for Special Class Premium _____

Proposed Risk Class _____ Automatic Premium Loan ☐ Yes ☐ No

Riders/Benefits

☐ Accidental Death $ _____
☐ Assured Insurability $ _____
☐ Charitable Giving (Term)
☐ Children's Term _____ units
☐ Spouse's Term _____ units
☐ Waiver of Premium (Non-UL)
☐ Other _____

UL Only:
☐ Additional Life Insurance $ _____
☐ Cost of Living
☐ Disability Payment of Premium $_____
☐ Extra Protection $ _____
☐ Other Insured (complete information below)

UL Only:
☐ Automatic Growth
☐ Disability Continuance of Insurance
☐ Enhanced Living Benefits
☐ Living Benefits
☐ Monthly Benefit $_____
☐ Pension Increase
☐ Terminal Illness

Other Insureds (OI)

	Full Name (First, Middle, Last)		Marital Status	Specified Amount	
1st OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
2nd OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
3rd OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
4th OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____
5th OI	_____	☐ Non-Smoker ☐ Smoker	_____	$_____	☐ ADB $_____

Complete the following for all Other Insureds. If years employed is less than **two years**, specify the prior occupation in Special Requests. If any information is identical to the Primary Insured's, write **Same.**

	Social Security Number	State of Birth	Occupations and Exact Duties	Employer's Name and Address	Years Emp.
1st OI	_____	_____	_____	_____	_____
2nd OI	_____	_____	_____	_____	_____
3rd OI	_____	_____	_____	_____	_____
4th OI	_____	_____	_____	_____	_____
5th OI	_____	_____	_____	_____	_____

	Street Address, City, State, Zip	Telephone Number	Driver's License Number and State of Issue
1st OI	_____	(____) _____ ☐home ☐work	_____
2nd OI	_____	(____) _____ ☐home ☐work	_____
3rd OI	_____	(____) _____ ☐home ☐work	_____
4th OI	_____	(____) _____ ☐home ☐work	_____
5th OI	_____	(____) _____ ☐home ☐work	_____

BILLING INFORMATION

Premium Mode ☐ Ann ☐ SA ☐ Qtly ☐ Mo ☐* EPA ☐ GA ☐ CB ☐ FAP ☐ Single ☐ Other _____

* ☐ I request Kansas City Life to withdraw the **initial** monthly premium from my checking account to pay the premium on this policy. **(The initial draft will be drafted immediately on approval for a standard or better rate class. The Temporary Life Insurance Agreement, A133, is required.)**

Premium Notices Delivered To: ☐ Owner ☐ Primary Insured
☐ Other (provide name and address) _____

Modal Premium Amount for Other Financial Services $_____

Branch of Service for GA _____

Payor's SSN for Government Allotment _____

REPLACEMENT

1) Will any existing life or annuity contract be lapsed, reissued, surrendered, or converted (to reduce amount, premium, or period of coverage, including surrender options) if the proposed policy is issued? ☐ Yes ☐ No
2) Will the proposed policy be financed by loans from this or any other policy or annuity? ☐ Yes ☐ No
If **Yes**, provide name of company(ies) or amount(s) _____
3) Will the proposed policy be part of an Internal Revenue Code Section 1035 Exchange? ☐ Yes ☐ No

EVIDENCE OF INSURABILITY

Insurance History

Do any of the proposed Insureds currently have life insurance coverage? ☐ Yes ☐ No
(If **Yes**, fill out the table below; if **No**, proceed to question 1 directly below the table.)

Proposed Insured(s)	Company	Year Issued	Insurance Amount	ADB Amount
			$	$
			$	$
			$	$
			$	$

1) In the **last three years,** have any of the proposed Insureds applied for life or health insurance or reinstatement thereof without receiving it exactly as requested? ☐ Yes ☐ No
2) Do any of the proposed Insureds have an application for life or health insurance pending at any other insurance company or intend to apply for such insurance within the next 10 days? ☐ Yes ☐ No

Provide details to all **Yes** answers. _____

FINANCIAL INFORMATION

Complete For Personal Insurance Sales

Purpose of insurance (Check all that apply) ☐ Family Income Protection ☐ Mortgage Protection ☐ Estate Planning ☐ Retirement Savings ☐ College Savings ☐ Final Expenses ☐ Other _____

Annual earned income (Include Salary, Bonus, Commissions)

☐ Proposed Insured $_____ ☐ Other Insured $_____

☐ Spouse $_____ ☐ Family net worth $_____ (Total assets minus total liabilities)

Has(Have) the proposed Insured(s) ever filed for bankruptcy? ☐ Yes ☐ No

If **Yes**, please provide type (Chapter ☐ 7, ☐11, ☐13) and date closed. _____

Spouse's Occupation _____ Amount of life insurance in force on Spouse $_____

Complete For Business Insurance Sales

Purpose of insurance (Check all that apply) ☐ Key Person ☐ Deferred Compensation ☐ Buy/Sell ☐ Creditor ☐ Other _____

For the option(s) checked, how was the amount of insurance determined? _____ (Please provide documentation)

Annual earned income of proposed Insured $_____ Proposed Insured's ownership of company _____%

Are other owners, officers, or key persons being insured? ☐ Yes ☐ No If **No**, please explain. _____

Total assets of company $_____ Total liabilities of company $_____

Net worth of company $_____ Net income of company after taxes last fiscal year $_____

Has company ever filed bankruptcy? ☐ Yes ☐ No If **Yes**, please provide type (Chapter ☐7, ☐11, ☐13) and date closed._____

NON-MEDICAL UNDERWRITING QUESTIONS

Questions apply to all proposed Insureds*

1) Do any of the family members listed on this application live outside the Primary Insured's household?..... ☐ Yes ☐ No

2) Are any proposed Insureds not a U.S. citizen? ..... ☐ Yes ☐ No
If **Yes**, how long has(have) the proposed Insured(s) been in the United States?_____
Visa type?_____ Visa number? _____

3) Have any of the proposed Insureds in the last 12 months, or do any of the proposed Insureds within the next 24 months, intend to travel or reside outside the continental U.S. or Canada? If **Yes**, explain below..... ☐ Yes ☐ No

4) In the **last three years**, has any proposed Insured:
   a) been cited or convicted for any moving motor vehicle violations? If **Yes**, explain below. ..... ☐ Yes ☐ No
   b) had a driver's license suspended or revoked? If **Yes**, explain below. ..... ☐ Yes ☐ No
   c) flown as a pilot, co-pilot, or crew member of an aircraft? If **Yes**, complete the Aviation Questionnaire. ..... ☐ Yes ☐ No
   d) engaged in sky or scuba diving, hang gliding, racing or any other hazardous sport or hobby? If **Yes**, complete the Avocations Questionnaire. ..... ☐ Yes ☐ No

5) Has any proposed Insured ever been convicted of a felony? If **Yes**, explain below. ..... ☐ Yes ☐ No

6) For proposed Insured **(a)** and Other Insureds **(b)**, is there any **family history** of diabetes, cancer, high blood pressure, heart or kidney disease, mental illness, suicide, or stroke? If **Yes**, explain below..... ☐ Yes ☐ No

Relationship	Age if Living **(a)**	**(b)**	Family History or Cause of Death	Age at Death **(a)**	**(b)**
Father					
Mother					
Brothers and Sisters					

*****Provide details to all **Yes** answers. _____

JUVENILE INSURANCE (AGE 0-17)

1) If any proposed Insured(s) is(are) less than one year old, what was birth weight? (name and birth weight) _____

2) If any proposed Insured(s) is(are) age 5-15, what is grade in school? (name and grade) _____

3) Are all children insured equally? ☐ Yes ☐ No If **No**, please explain. _____

4) Amount of insurance in force on father $_____

5) Amount of insurance in force on mother $_____

HEALTH STATEMENT

Print full names of all to be insured.	Relationship to Primary Insured	Birthdate			Age	Sex	Build			*Weight Change in the Past Year	
		Month	Day	Year			Ft.	In.	Lb.	Gain	Loss
1) Primary Insured	X	X	X	X	X	X					
2)											
3)											
4)											
5)											
6)											

Questions apply to all proposed Insureds*

	YES	NO
1) Do you take prescription medicine?		
2) Are you currently pregnant? Due date? _____		
3) Have you ever received treatment from a physician or counselor regarding the use of alcohol, or for the use of drugs except for medicinal purposes, or received treatment or advice from an organization that assists those who have an alcohol or drug problem?		
4) Have you used any form of nicotine/tobacco in the last 12 months (e.g. cigar, pipe, smokeless tobacco, cigarettes, etc.)? If cigarettes, how many packs per day? _____		
5) Have you ever used heroin, cocaine, barbiturates, or other drugs, except as prescribed by a physician or other licensed practitioner?		
6) During the last five years, have you been hospitalized or had medical advice, diagnostic tests recommended, or treatment by a physician or other medical practitioner?		
In the last 10 years, have you been diagnosed or treated for any disease or disorder of:		
7) Brain and nervous system: Mental illness, epilepsy, seizures, stroke, paralysis?		
8) Sight or hearing?		
9) Blood: anemia or leukemia?		
10) Tumor or cancer?		
11) Heart/blood vessels: murmur, chest pain or pressure, palpitations, heart attack?		
12) Blood pressure?		
13) Thyroid or glandular trouble?		
14) Lungs: asthma, emphysema, tuberculosis?		
15) Digestive system: ulcer, intestines or rectum, polyps, colitis?		
16) Liver: elevated enzymes, cirrhosis, hepatitis?		
17) Diabetes, sugar in urine?		
18) Kidney, bladder or prostate: albumin, blood, or pus in urine?		
19) Muscles, bones, or joints (e.g. arthritis)?		
20) Breasts, uterus, or ovaries?		
21) Menstruation or pregnancy?		
Have you ever been diagnosed or treated for:		
22) A sexually transmitted disease?		
23) Acquired Immune Deficiency Syndrome (AIDS) or tested HIV positive?		

*Provide details to all **Yes** answers. Identify proposed Insured(s), question, specify conditions, severity, dates, duration, after-effects, weight gain or loss, and names and addresses of all attending physicians and medical facilities.

Names, addresses, and phone numbers of personal or family physicians. (If none, list last physician, clinic, or hospital consulted.)

Date and Reason Last Consulted

Clinic or VA Claim Number

Civilian Aviation Questionnaire

Name of proposed Insured _____

As a pilot or student pilot, indicate the number of hours flown in command _____ Date of last flight _____

Type of license currently held ☐ Commercial ☐ Student ☐ Private

Do you hold a valid instrument rating? ☐ Yes ☐ No

Number of hours flown in the last 12 months _____ Number of hours flown in the last 12-24 months _____ Number of flying hours contemplated in next 12 months _____

Purpose of present and future flying ☐ Pleasure ☐ Personal Business ☐ Commercial ☐ Other (specify) _____

Type and class of aircraft flown ☐ Propeller ☐ Glider ☐ Home-Built ☐ Jet ☐ Balloon ☐ Ultralite ☐ Helicopter ☐ Hang Glider

Do you expect to engage in any of the following types of flying within the next 12 months? If **Yes**, state which and number of hours.

	Hours		Hours	
☐ Scheduled Airlines	_____	☐ Pipeline Inspection	_____	
☐ Nonscheduled Airlines	_____	☐ Air Taxi or Sight Seeing	_____	
☐ Employer Owned Aircraft	_____	☐ Photography	_____	
☐ Crop Dusting	_____	☐ Mapping	_____	
☐ Water Bombing	_____	☐ Test or Inspection Flying	_____	
☐ Student Instruction	_____	☐ Aerobatics	_____	
☐ Charter Flying	_____	☐ Racing	_____	
☐ Freight or Mail Carrying	_____	☐ Any Other for Pay Flying	_____	Type _____

Have you ever:

a) been in an aircraft accident? ☐ Yes ☐ No If **Yes** to a, b, or c, explain below in Additional Details.

b) been grounded? ☐ Yes ☐ No

c) been fined or reprimanded? ☐ Yes ☐ No

Do you have any operational limitations on your medical certificate? ☐ Yes ☐ No If **Yes**, explain below in Additional Details.

Do you contemplate flying in Alaska? ☐ Yes ☐ No

Do you contemplate flying outside the continental United States? ☐ Yes ☐ No If **Yes**, explain below in Additional Details.

If aviation required an extra premium or exclusion rider, which would you prefer? ☐ Extra Premium ☐ Exclusion Rider

Additional Details

Avocations Questionnaire

Name of proposed Insured _____

UNDERWATER DIVING

	Average Depth	Average Time (minutes)	Last 12 Months	1 to 2 Years Ago	Estimated Next 12 Months
	0-65 ft.				
	66-100 ft.				
	101-150 ft.				
	Over 150 ft.				

Frequency (Days)_____

Type ☐ Scuba ☐ Skin or snorkel

Purpose

☐ Recreation ☐ Wreck/Salvage/Retrieval ☐ Commercial

☐ Search/Rescue ☐ Instructor ☐ Other _____

Certification (Check highest certificate attained.)

☐ Basic ☐ Open-Water ☐ Advanced Open Water ☐ Dive Master/Instructor ☐ No Certificate

Locations

☐ Lakes ☐ Rivers ☐ Oceans

☐ Quarries ☐ Pools ☐ Other _____

Do you use the "buddy system"? ☐ Yes ☐ No Do you engage in ice diving? ☐ Yes ☐ No

Do you engage in cave diving? ☐ Yes ☐ No Date of last dive _____

PARACHUTING OR SKYDIVING

☐ Amateur
☐ Professional

Association or club member ☐ Yes ☐ No

Number of years _____ Date of last jump _____ Average number of jumps per year _____

Do you compete for record attempts? ☐ Yes ☐ No Do you use experimental equipment? ☐ Yes ☐ No

AUTOMOBILE RACING

Type of vehicle used in races? _____ What is the maximum speed attained? _____ What is the average speed attained? _____

Purposes of racing ☐ Amateur ☐ Professional ☐ Both (provide details) _____

How many races did you enter in the last 12 months? _____ How many races did you enter in the last 13-24 months? _____ How many races do you contemplate in the next 12 months? _____

☐ Championship (Indy Cars)

☐ Demolition

☐ Drag Racing (Circle those that apply: Funny Car, Top Fuel, Pro Stock, Modified Production, Modified Super Stock, Pure Stock)

☐ Formula Racing (Circle those that apply: Formula One, Supervee, Vee, Ford)

☐ Midget Car Racing

☐ Sports Car Racing (Circle those that apply: CanAm, TransAm, Production, A, B, C, All American GT, Showroom Stock, Vintage Sports)

☐ Stock Car (Circle those that apply: NASCAR Winston Cup Division, Winston Division, NASCAR Busch Grand National Division, NASCAR Modified Division, USAC Super Modified Division, Amateur, Street Stock, Hobby Division)

☐ Racing not covered above (provide type and details). _____

_____

OTHER AVOCATIONS

(Please provide details in Remarks section.)

☐ Ballooning ☐ Mountain or Rock Climbing ☐ Bungee Jumping

☐ Hang Gliding ☐ Motorboat or Powerboat Racing ☐ White Water Rafting

☐ Ultralite Flying ☐ Motorcycle Racing ☐ Other

Remarks

Military Questionnaire

Name of proposed Insured _____

Permanent Address (non-military residence) _____

STATUS

Branch of Service _____

Date entered active service _____ Present pay grade _____

Name and location of present unit _____

Have you or your unit been alerted for overseas assignment? ☐ Yes ☐ No

If **Yes**, where? _____

Usual duty assignment (e.g., Tank Mechanic, Cook, Radar Operator, etc.) _____

Do you qualify for hazardous duty pay? ☐ Yes ☐ No

If **Yes**, why? (e.g., flying duty, submarine duty, etc.). _____

Have you any reason to believe you will, within the next 90 days, be transferred or have you any knowledge of any change in activities? ☐ Yes ☐ No

If **Yes**, provide details _____

MILITARY AVIATION

How many total hours have you accumulated as a pilot or as a crew member? _____

Hours estimated in the next 12 months as a pilot or as a crew member? _____

Job title _____ Aviation activity and duties _____

Do you fly for proficiency only? ☐ Yes ☐ No

If **Yes**, specify hours flown and provide full details _____

Duty assignment (MAC, SAC, TAC, etc.) _____

Aircraft in which duties are performed (F4, B52, T28, HO-1, etc.) _____

Agreement

It is understood and agreed as follows:

1) The statements and answers recorded in all parts of this application are true and complete.
2) No information regarding any proposed Insured will be considered known by the Company unless explicitly set out in writing on this application.
3) This application and the answers to any required medical exam will become a part of any policy issued on it.
4) No agent has the authority to waive any of the Company's rights or rules or to make or change any contract.
5) The insurance applied for will take effect only after the following occur while the proposed Insured(s) is(are) living and his/her(their) health is as stated in this application: (1) the policy is delivered to the applicant; and (2) the first full premium is paid in cash. The only exception to this is provided in the Temporary Life Insurance Agreement if the agreement has been issued and the advance payment required by the agreement has been made.
6) Any changes or additions made by the Company in "Home Office Endorsements" will be ratified by the applicant's acceptance of any life insurance policy issued on this application. However, any change in the classification, amount of insurance, issue age, plan of insurance or any benefits will not be effective unless accepted in writing by me(us).
7) I(We) have received the Notice of Information Practices which explains my(our) rights under the Fair Credit Reporting Act.
8) I(We) have paid $_____* to the agent in exchange for the Temporary Life Insurance Agreement and I(we) acknowledge that I(we) fully understand and accept its terms.

***All premium checks must be made payable to Kansas City Life Insurance Company. Do not make the check payable to the agent or leave the payee blank.**

(Continued on next page)

(Continued from previous page)

Authorization for the Release of Medical Information
To obtain a copy of or to revoke this authorization, contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-7073

This authorization applies to all persons whose signatures appear below. The proposed Primary Insured and all other proposed Insureds must sign.

I authorize any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Kansas City Life Insurance Company or any person acting on behalf of Kansas City Life Insurance Company. I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. "Information" means facts regarding my physical or mental condition (including the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection; sexually transmitted diseases; mental illness; the use of alcohol, drugs, and tobacco; but excluding psychotherapy notes); employment; other insurance coverage; financial status; or any other relevant information about me or my minor children. Information obtained will be released only to reinsurers; MIB, Inc.; persons and entities performing business duties as delegated or contracted for by Kansas City Life Insurance Company related to my application and subsequent insurance-related functions as permitted or required by law or as I further authorize. Some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any health plan; physician; health care professional; hospital; clinic; laboratory; pharmacy or pharmacy benefit manager; medical facility; or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("My Providers"); MIB, Inc.; insurers; reinsurers; government agencies; consumer reporting agencies and/or employers to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this authorization so that Kansas City Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Kansas City Life Insurance Company.

This authorization shall remain in force for 36 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing at any time by providing written notification to the entity identified above, and I understand that a revocation is not effective to the extent that any of My Providers has already relied on this authorization to disclose information about me or to the extent that Kansas City Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by the recipient except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization or otherwise condition my enrollment or eligibility for health benefits on my signing this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Kansas City Life Insurance Company may not be able to process my application or, if coverage has been issued, may not be able to make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ this _____ day of _____, 20_____.
City/State **Month** **Year**

_____ _____
Primary Insured's Signature (if under 15, parent/guardian signature) **Applicant's Signature (if other than Primary Insured)**

_____ _____
Spouse's Signature (if spouse coverage applied for) **First Other Insured's Signature (if over age 18)**

_____ _____
Second Other Insured's Signature (if over age 18) **Third Other Insured's Signature (if over age 18)**

_____ _____
Fourth Other Insured's Signature (if over age 18) **Fifth Other Insured's Signature (if over age 18)**

Statement of Agent

I certify that the statements of the Primary Insured, applicant and any other proposed Insured(s) have been correctly recorded in this application and that any premium payment shown in item 8 under Agreement on page 9 has been collected by me and that a Temporary Life Insurance Agreement has been given to the applicant.

To the best of my knowledge, the insurance applied for in this application ☐ will ☐ will not replace existing insurance.

Did you see all proposed Insureds at the time of application? ☐ Yes ☐ No (If **No**, an examination may be required.)

Agent Code	**Signature of Writing Agent**
Agency Code	**Agency**

Agent Code	**Signature of Other Agent(s) (if split case)**

KANSAS CITY LIFE INSURANCE COMPANY

Pre-Authorized Check Plan (PAC)

PAC Instructions

1) This form is to be used to request the establishment of a new PAC plan or change banks or accounts under an existing PAC plan. Do not use this form to add a policy to an existing PAC plan. Instead, simply provide the existing PAC plan number in the Special Requests section of the application.
2) **Attach a personalized sample check from the account to be used.**
3) The total monthly premium on all policies in a PAC plan must be at least $10.

Request for PAC: I request Kansas City Life Insurance Company to make monthly withdrawals from my checking account to pay premiums on this policy applied for or to make monthly withdrawals from my checking account to pay premiums on the following additional pending applications. (Include name of proposed Insured(s) and policy number if available.)_____

Draft Date: I request Kansas City Life Insurance Company to draw the PAC check or debit entry on or after the _____***** day of the month.
***** Available draft days are the 1st through the 28th.

Account Information

Payor's Name_____

Bank Name_____ Branch Name (if any)_____

☐ Checking ☐ Savings Account Number_____Bank Transit Number_____

Bank's Address where Account is Maintained _____
Street **City** **State** **Zip**

Agreement for Automatic Premium Payments and Authorization to Honor Checks Drawn by the Company

It is agreed that:

1) This PAC plan does not change any policy provisions. The payor's authorization is not in lieu of payment in cash of the first premium and does not constitute advance payment required by the Temporary Life Insurance Agreement.
2) Upon 30 days written notice, this PAC plan may be stopped or changed at any time by: the owner of any policy under this PAC plan, the Company, or the payor.
3) Withdrawals will be made on or about the premium draft date shown above.
4) No premium notices or receipts will be sent. Debit entries or checks, when paid, will constitute receipts for premiums.
5) The privilege of paying premiums under this PAC plan may be revoked by the Company if any check or debit entry is not paid upon presentation.
6) The Company's rights in respect to each check and/or debit entry will be the same as if I signed it personally.
7) If any debit or check entry is dishonored, the Company will be under no liability whatsoever, even if such dishonor results in forfeiture of insurance.
8) I authorize the Company to pay and charge to my(our) account, debit entries or checks drawn by and payable to the order of the Company, provided there are sufficient collected funds present to pay same upon presentation. This authorization will remain in effect until revoked by me in writing, a copy of which will be sent to the Company. Until the Company receives such notice, I agree that the Company will be fully protected in honoring any such debit.

Date_____ Signature of Premium Payor _____

KANSAS CITY LIFE INSURANCE COMPANY

To obtain further information contact:
New Business Department
Kansas City Life Insurance Company
PO Box 219371
Kansas City, MO 64121-7073

NOTICE OF INFORMATION PRACTICES

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

Thank you for your application. It is the major source of information about you which we use in evaluating your application and issuing your contract. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living (except as may be related directly or indirectly to your sexual orientation) as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the address above. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency.

We are committed to protecting the privacy of our customer's nonpublic personal information. We will only disclose our customer's nonpublic personal information: among the affiliated companies of the Kansas City Life Group; to provide services to our customers and administer our business; to market products; and as otherwise permitted by law. We may disclose our customer's nonpublic personal information to our agents and representatives to provide services to our customers and for marketing purposes. When we contract with other entities to provide support or marketing services, we will require them to adhere to our privacy standards.

Sometimes we acquire medical information about our customers, for instance, to underwrite an insurance contract or to process an insurance claim. We will keep our customer's medical information confidential. We will not share our customer's medical information even among the affiliated companies of the Kansas City Life Group without the customer's consent. We will only use or disclose our customer's medical information to underwrite insurance, process claims, administer our business, to comply with laws and regulations or as otherwise authorized by our customers.

You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our New Business Department, Kansas City Life Insurance Company, PO Box 219371, Kansas City, MO 64121-7073.

MIB, Inc. Notice

Information regarding your insurability will be treated as confidential. Kansas City Life Insurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Kansas City Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

SERFF Tracking #:	*KCLF-128617026*	***State Tracking #:***		***Company Tracking #:***	*A167*

State:	*Arkansas*	***Filing Company:***	*Kansas City Life Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*A167 - Application*		
Project Name/Number:	*A167 - Application/A167*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Filing Certification - Arkansas.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Cover Letter		
Comments:	Attached is a cover letter that describes the filing.		
Attachment(s):			
Cover Letter - Arkansas.pdf			

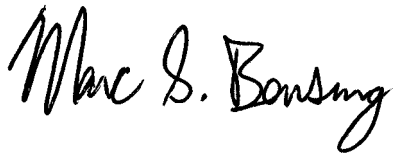
STATE OF ARKANSAS
COMPLIANCE CERTIFICATION

COMPANY NAME: Kansas City Life Insurance Company

FORM TITLE(S): Application for Life Insurance

FORM NUMBER(S): A167-AR

I hereby certify that to the best of my knowledge and belief, the above form and submissions is in compliance with Regulation 19, Regulation 49, and all other laws, rules and regulations of the State of Arkansas.



Marc S. Bensing
Assistant Vice President
Kansas City Life Insurance Company

August 8, 2012

KANSAS CITY LIFE
INSURANCE COMPANY
Broadway at Armour / Box 219139 / Kansas City, Missouri 64121-9139
Telephone: (816) 753-7000

August 7, 2012

Arkansas Department of Insurance
1200 W. Third Street
Little Rock, Arkansas 72201-1904

RE: Kansas City Life Insurance Company
NAIC: 65129-588
FEIN: 44-0308260
Informational Filing: MIB mandated change to Application for Life Insurance

Dear Sir or Madam:

With this filing, Kansas City Life Insurance Company is submitting for review and approval A167-AR, Application for Life Insurance. The Medical Information Bureau, MIB, has mandated a change to the Authorization for the Release of Medical Information. The required change has been made to previously approved A160-AR to comply with the MIB mandated change. A160-AR was approved by the Arkansas Department of Insurance on February 18, 2010.

The Authorization for the Release of Medical Information contained on page 10 has been amended to include the required change to the authorization. The following sentence has been added to the first paragraph on page 10 of A167-AR: "I authorize Kansas City Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB." No part of the application has been altered or changed, and remains identical to the previously approved A160-AR.

Please direct all inquiries regarding this filing to me at the address, phone number, or email address contained in the file.

Sincerely,

Bobby Stow
Compliance Analyst
Kansas City Life Insurance Company
Phone: 800.821.6164
Ex: 8852
Email: bstow@kclife.com